THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
ACTION AGENDA SUMMARY

DEPT: Health Services Agency mat **BOARD AGENDA #** *B-7

Urgent ☐ **Routine** ■ **AGENDA DATE** December 20, 2011

CEO Concurs with Recommendation YES ☒ **NO** ☐ **4/5 Vote Required YES** ☐ **NO** ■
(Information Attached)

SUBJECT:

Approval of the Temporary Extension of the Local Initiative Medi-Cal Managed Care Health Plan Designation of Anthem Blue Cross and Approve the Temporary Overlap of the Designation of Health Plan of San Joaquin and Associated Actions

STAFF RECOMMENDATIONS:

1. Approve the temporary extension of the Local Initiative Medi-Cal Managed Care Health Plan Designation of Anthem Blue Cross for the duration of the lesser of the corresponding health care service plan contract between the State of California and Anthem Blue Cross relative to Stanislaus County or through December 31, 2012, to accommodate the State of California's delayed implementation of the Health Plan of San Joaquin as the Board of Supervisor's designated replacement of the Local Initiative Medi-Cal Managed Care Health Plan.

(Continued on Page 2)

FISCAL IMPACT:

The Adopted Final Budget for the 2011-2012 Fiscal Year for the Health Services Agency (HSA) is $88,037,000. The HSA had planned to propose budget changes in the mid-year budget submission based on the anticipated implementation of Health Plan of San Joaquin (HPSJ) as the new Local Initiative Medi-Cal Managed Care health plan in Stanislaus County. Although the HSA projections for the Budget

(Continued on Page 2)

BOARD ACTION AS FOLLOWS:

No. 2011-779

On motion of Supervisor Chiesa **, Seconded by Supervisor** De Martini
and approved by the following vote,
Ayes: Supervisors: O'Brien, Chiesa, Withrow, De Martini, and Chairman Monteith
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

1) X Approved as recommended
2) Denied
3) Approved as amended
4) Other:
MOTION:

Christine Ferraro

ATTEST: **CHRISTINE FERRARO TALLMAN, Clerk** **File No.**

STAFF RECOMMENDATIONS (Continued):

2. Authorize the Health Services Agency Managing Director to extend the duration of the twelve month advance termination notice of the Administrative Services Subcontract Agreement issued December 10, 2010 to Anthem Blue Cross for up to an additional one year and to negotiate and execute an amended Administrative Services Subcontract Agreement with Anthem Blue Cross.

3. Approve the temporary overlap of the Local Initiative Medi-Cal Managed Care Health Plan Designation to acknowledge the State's decision to temporarily continue operations through Anthem Blue Cross and to accommodate the Health Services Agency's and local provider stakeholders need to continue to plan and coordinate the future operational implementation of the Health Plan of San Joaquin.

FISCAL IMPACT (Continued):

Year 2011-2012 were adjusted relative to the anticipated expiration of the Anthem Blue Cross Administrative agreement, staff will reassess projections for the mid-year budget submission based upon the actual completion of related agreements.

Average annual administrative revenue from Anthem has been approximately $750,000. Approval of the staff recommendations would avoid an interruption of and preserve a necessary funding source during the State's temporary delay of the implementation of HPSJ as the new Local Initiative Medi-Cal Managed Care health plan in Stanislaus County.

DISCUSSION:

A Request for Proposal (RFP) process was initiated in January of 2011 in an effort to identify a Medi-Cal Managed Care Health Plan to serve as the future Local Initiative health plan for Stanislaus County. The top ranking proposer, Health Plan of San Joaquin (HPSJ) was designated by the Board of Supervisors on May 10, 2011 as the Local Initiative Medi-Cal Managed Care Health Plan effective January 1, 2012. Despite significant coordination between the Health Services Agency (HSA) and the State Department of Health Care Services (DHCS) prior to and during the RFP process, the DHCS has recently decided to delay their implementation of this designation for an entire year. Due to this unilateral State DHCS decision, staff recommends the consideration of modifications to related policy decisions made by the Board of Supervisors on December 7, 2010 and May 10, 2011.

Background on Medi-Cal Managed Care Two-Plan Model and "Local Initiative"

In 1993, the California Department of Health Services, now known as the Department of Health Care Services (DHCS), issued its strategic plan for expansion of managed care in the Medi-Cal program. This plan targeted thirteen (13) counties in which DHCS contracted with two licensed health maintenance organizations (HMOs) to take care of all Medi-Cal recipients within three primary aid categories. Of these two HMOs, one was to be an existing "Commercial" plan selected by the State DHCS, while the counties were given the option to develop the other plan called the "Local Initiative." With the State DHCS approval, Stanislaus County decided to pursue a contract relationship rather than develop a County-operated health plan. Under this model, the State negotiates, enters the main contract with and provides the funding to the health plan for the provision of medical services, while the local Board of Supervisors retains the discretion to choose the health plan.

Following a County RFP process, Blue Cross of California (now known as Anthem Blue Cross "Anthem") was designated by the Board of Supervisors to serve as Stanislaus County's Local Initiative Health Plan and has served in that role since the initial launch in 1997. Although an RFP process was conducted in 2008, due to a termination notice issued by Anthem to the State, no staff recommendation was made as a result of that RFP as Anthem and the State reached subsequent agreement.

Withdraw of Designation

On August 23, 2010, HSA staff met with DHCS representatives and confirmed that the current agreement between Anthem and DHCS was to expire on December 31, 2011. The corresponding Administrative Agreement between the HSA and Anthem requires a twelve (12) month advance termination notice (or automatically terminates upon the termination of the Anthem/DHCS agreement).

Prior to forming a recommendation to the Board of Supervisors a year ago, the HSA convened a meeting with major safety net provider stakeholders such as Doctors Medical Center, Golden Valley Health Centers, Scenic Faculty Medical Group and the HSA's Clinic and Ancillary division to seek input. Attendees demonstrated a high level of interest in working together toward a model which better aligns incentives and pursues a new level of locally engaged integrated care delivery for access and outcomes improvement. This stakeholder group acknowledged the need for a collaborative and flexible relationship with a health plan interested and committed to our community and the improvements that are possible with increased local stakeholder involvement. There was unanimous support for re-assessing the health plan market.

On December 7, 2010, the Board of Supervisors approved the HSA recommendation to issue the twelve-month advance notice of withdraw of the Local Initiative designation to Anthem. On December 10, 2010, notification letters were sent to both Anthem and DHCS with a designation withdrawal effective date of December 31, 2011.

Based upon an RFP process, on May 10, 2011, the Board of Supervisors awarded HPSJ the designation of the Local Initiative Medi-Cal Managed Care Health Plan for Stanislaus County effective January 1, 2012. The Agency then notified DHCS of the designation such that the readiness review could commence. As had been conveyed by DHCS representatives to the HSA in earlier timeline planning, DHCS upon the local decision would conduct its readiness review and negotiate a contract with the HPSJ; a process which was estimated by DHCS representatives to require approximately eight months. The HSA would also enter into negotiations with HPSJ for a related contractual arrangement based on the HPSJ submitted proposal. The actual start date of HPSJ with assigned Medi-Cal Managed Care patients was to be determined by DHCS, however was targeted for January 1, 2012 to avoid an interruption in a Local Initiative health plan option and to coincide with the expiration of the DHCS contract with Anthem Blue Cross.

Following the Board of Supervisors May 10, 2011 designation of HPSJ
HSA immediately notified DHCS representatives, followed by a formal written letter on May 13, 2011 accompanied by a copy of the approved May 10, 2011 Board Action #2010-736. The HSA and HPSJ then launched periodic meetings to plan for the implementation and collaborative initiatives intended. In mid-summer, with the HSA aware that no efforts by State DHCS had been made to begin the readiness review with HPSJ, the HSA learned of DHCS' intention to delay implementation for a yet to be determined duration and to extend the current agreement with Anthem. Despite HSA's resistance, HSA was then told by DHCS representatives that by approximately August 1, 2011, DHCS would be providing written notice to HSA of DHCS' planned effective date which would likely be a date after September 2012 and most likely be January 1, 2013 to coincide with the implementation of the planned State RFP award for the commercial Medi-Cal Managed Care health plan for Stanislaus County.

Since the DHCS intent to extend the Anthem contract beyond December 31, 2011 would mean it would be contracting with a non-Board of Supervisors designated health plan to serve as the Local Initiative, HSA requested documentation regarding the State's discretion. Although it was verbally promised, to date no such documentation or explanation has been provided.

By early October, the State DHCS still had not initiated the HPSJ readiness review, nor announced or provided notice of an implementation date.

This problem was shared with the Health Executive Committee of the Board of Supervisors on October 3, 2011. Shortly thereafter, the Agency reached the Deputy Director of DHCS, who committed to researching the matter further and would internally

consider whether a July 1, 2012 implementation would be possible instead of the yet announced but DHCS intended one year delay.

State Notification of Delay

HSA efforts for a follow-up conversation were to no avail and on November 16, 2011, a letter was received from DHCS (Attachment A) conveying DHCS' decision to implement the HPSJ effective January 1, 2013, and to extend the Anthem Blue Cross agreement for another year, through December 31, 2012. This would coincide with the planned implementation date by DHCS of their yet awarded commercial Medi-Cal Managed Care health plan. It is the Agency's understanding that both Anthem Blue Cross – the existing Local Initiative health plan, and Health Net, the existing DHCS contracted commercial health plan, are among those that responded to the DHCS' RFP for the future commercial contract.

Although the Agency desires an earlier HPSJ implementation date, the Agency intends to continue working with the HPSJ on planned collaborative efforts relative to the RFP award. Given the present lack of ability for local influence over the DHCS implementation timing, the DHCS' conveyed extension efforts with Anthem Blue Cross, and the ongoing need for the continued financial support provided by Anthem to the HSA under the Administrative agreement to support and enhance the services provided to Local Initiative Medi-Cal Managed Care beneficiaries, the Agency recommends the Board of Supervisors acknowledgement of the temporary DHCS delay and extension, while preserving the RFP based designation of the HPSJ for future implementation.

POLICY ISSUE:

Approval of this recommendation is consistent with the Board of Supervisors' priorities of A Healthy Community, Efficient Delivery of Public Services, and Effective Partnerships by supporting the RFP award and the development of a new collaborative arrangement with Health Plan of San Joaquin, while acknowledging the State controlled delay and temporary extension of the Anthem relationship by preserving continuity for patients and funding to HSA for supportive services.

STAFFING IMPACT:

There is no impact to the allocation of positions as a result of these recommendations, however the lack of communication and the implementation delay by the State DHCS has necessarily required an inefficient and unplanned use of staffing resources.

DEPARTMENTAL CONTACT:

Mary Ann Lee, Managing Director, 209-558-7163.

State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

November 16, 2011

Mary Ann Lee, Managing Director
Stanislaus County
Health Services Agency
P.O. Box 3271
Modesto, CA 95353

RE: Stanislaus County Local Initiative Designation

Dear Ms. Lee:

Thank you for your letter dated May 13, 2011, notifying the Department of Health Care Services (DHCS) of Stanislaus County's designation of Health Plan San Joaquin (HPSJ) as the new Local Initiative (LI). HPSJ will replace Anthem Blue Cross (Anthem) as the designated LI.

After separate discussions with Stanislaus County representatives and HPSJ, DHCS has determined January 1, 2013 is the best transition for HPSJ to assume operations as the designated LI. This date resolves any concerns held by the Centers for Medicare and Medicaid Services (CMS) and DHCS, regarding implementation overlap with the transition of the Seniors and Persons with Disabilities population into managed care and provides DHCS, CMS, Department of Managed Health Care, and HPSJ adequate time to complete all plan-readiness activities and secure approvals. HPSJ met with DHCS and proposed a timeline that indicated this is an acceptable date and ensures there are no conflicts that could cause member confusion within the County.

For your reference, enclosed please find a copy of the implementation work plan and timeline. In addition, to assure continuity of care for existing Anthem members, DHCS will be extending Anthem's contract in Stanislaus County through December 31, 2012.

DHCS looks forward to a successful implementation of HPSJ in Stanislaus County. A kick-off meeting scheduled for Friday, November 18, will begin all readiness activities with HPSJ. If you have any questions, please contact Javier Portela at (916) 449-5234 or by email at Javier.portela@dhcs.ca.gov.

Sincerely,

Javier Portela, Chief
Plan Management Branch
Medi-Cal Managed Care Division
Department of Health Care Services

Enclosures
cc: See next page.

cc: Jane Ogle
Deputy Director
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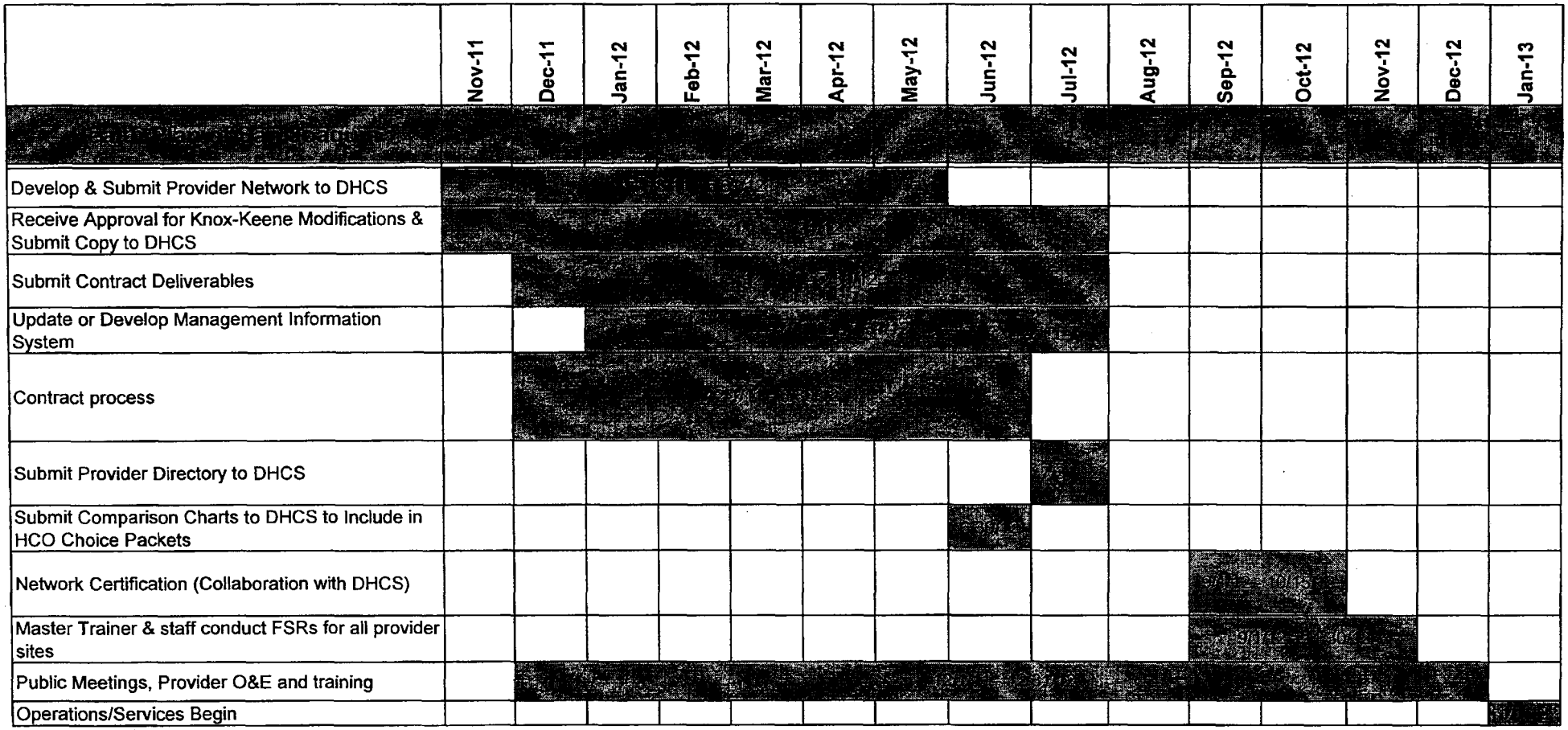
Health Plan of San Joaquin
7751 South Manthey Road
French Camp, CA 95231-9802

Stanislaus County
Implementation Timeline (1/1/13)



Stanislaus County
Implementation Timeline (1/1/13)

	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Department of Health Care Services (DHCS)															
Deliverable Review and approve															
Contract Process															
Receive/review/approve provider network															
Review/Approve Provider Directories (PDs)															
Finialize member outreach processes and material, Including any service area Carve-outs and Beneficiary Notices to Health Care Options (HCO)															
SSU Memo, HCP Requests, Provider Bulletin, and Provider Manual to SSU for necessary system changes															
Review/Approve Plan Comparison Charts															
Submit Online PDs & Comparison Charts to HCO															
CMS review and approval															
DHCS Readiness Review/FSRs															
Public Notice Published in Local Newspaper* (assumes no concerns from CMS on approval)															
First Notice to Beneficiaries* (assumes no concerns from CMS on approval)															
Second Notice & Choice Packet to Beneficiaries															
Receive and processes choices and defaults for 1/1/13 effective date															
Operations/Services Begin															

WORK PLAN Attachement A

Required Health Plan Submissions

Deliverable Description	Del #	Date Due from Plan
Submit a complete organizational chart.	1.b.	12/2/2011
Contractor shall submit policies and procedures for ensuring that all appropriate staff receives sensitivity training relating to SPD beneficiaries.	1.k.	12/2/2011
Submit most recent audited annual financial reports. (For new contractors only)	2.a.	12/2/2011
Submit quarterly financial statements with the most recent quarter prior to execution of the Contract. (For new contractors only)	2.b.	12/2/2011
Describe any risk sharing or incentive arrangements. Explain any intent to enter into a stop loss option with DHCS. Also describe any reinsurance and risk-sharing arrangements with any subcontractors shown in this Proposal. Submit copies of all policies and agreements. For regulations related to Assumption of Financial Risk and Reinsurance, see Title 22, CCR, Sections 53863 and 53868.	2.e.	12/9/2011
Describe systems for ensuring that subcontractors who are at risk for providing services to Medi-Cal Members, as well as any obligations or requirements delegated pursuant to a subcontract, have the administrative and financial capacity to meet its contractual obligations. Title 28, CCR Section 1300.70(b)(2)(H)1. Title 22, CCR, Section 53250.	2.g.	12/9/2011
Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures. (For new contractors only)	2.h.	12/9/2011
Describe the process to ensure timely filing of required financial reports. The description should include mechanisms for systems oversight for generating financial and operational information, including a tracking system with lead times and due dates for quarterly and annual reports. Describe how this process coincides with the organization's management information system. Additionally, Contractor shall describe how it will comply with the Administrative cost requirements in Title 22, CCR, Section 53864(b).	2.i.	12/16/2011
Submit policies and procedures for a system to evaluate and monitor the financial viability of all subcontracting entities.	2.j.	12/16/2011
Submit policies and procedures for the complete, accurate, and timely submission of Encounter-level data.	3.e.	12/16/2011
Submit policies and procedures for performance of ProviderFacility Site and Medical Record reviews (FSR Attachments A and B), and for performance of Facility Site Physical Accessibility reviews (FSR Attachment C).	4.i.	12/16/2011
Submit a list of sites to be reviewed prior to initiating plan operation, existing or in expanded areas. (For New Contractors Only)	4.j.	12/23/2011
Submit policies and procedures for credentialing and re-credentialing.	4.m.	12/23/2011
Submit written description of UM program that describes appropriate processes to be used to review and approve the provision of medical services.	5.a.	12/23/2011
Submit policies and procedures for pre-authorization, concurrent review, and retrospective review.	5.b.	12/23/2011
Submit a list of services requiring prior authorization and the utilization review criteria.	5.c.	1/6/2012
Submit policies and procedures for the utilization review appeals process for providers and members.	5.d.	1/6/2012
Submit policies and procedures that specify timeframes for medical authorization.	5.e.	1/6/2012
Submit policies and procedures to detect both under- and over-utilization of health care services.	5.f.	1/6/2012
Submit policies and procedures showing how delegated activities will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved, and that UM activities are properly documented and reported.	5.g.	1/6/2012
Submit policies and procedures for providing emergency services.	6.d.	1/13/2012

WORK PLAN Attachement A

Required Health Plan Submissions

Deliverable Description	Del #	Date Due from Plan
Submit policies and procedures for how Contractor will ensure network provider hours of operation are no less than the hours of operation offered to other commercial or FFS patients.	6.i.	1/13/2012
Submit all boilerplate subcontracts. Signature page of all subcontracts and reimbursement provisions (confidential).	6.l.	1/13/2012
Submit protocols for payment and communication with non-contracting providers.	7.c.	1/13/2012
Submit copy of provider manual.	7.d.	1/13/2012
Submit policies and procedures for ensuring providers receive training on a continuing basis regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for SPD beneficiaries.	7.f.	1/13/2012
Submit policies and procedures for processing and payment of claims.	8.c.	1/20/2012
Submit policies and procedures regarding payment to non-contracting emergency services providers. Include schedule of per diem rates and/or Fee-for-service rates for each of the following provider types; 1) Primary Care Providers 2) Medical Groups and Independent Practice Associations 3) Specialists 4) Hospitals 5) Pharmacies	8.i.	1/20/2012
Submit policies and procedures that include requirements for: 1) Appointment scheduling 2) Routine specialty referral 3) First prenatal visit 4) Waiting times 5) After-hours calls 6) Unusual specialty services	9.a.	1/20/2012
Submit policies and procedures for ensuring the timely provision of access standards for: 1) Appropriate clinical timeframes 2) Standards for timely appointments 3) Shortening or expanding timeframes 4) Arranging timely appointments with a provider shortage.	9.b.	1/20/2012
Submit policies and procedures regarding 24-hr./day access without prior authorization, follow-up and coordination of emergency care services.	9.e.	1/20/2012
Submit policies and procedures regarding access for disabled members pursuant to the Americans with Disabilities Act of 1990.	9.i.	1/20/2012
Submit policies and procedures regarding Contractor and subcontractor compliance with the Civil Rights Act of 1964.	9.j.	1/20/2012
Submit policies and procedures for ensuring the provision of the Initial Health Assessments (IHA) for adults and children, including the Initial Health Education Behavioral Health Assessment (IHEBA) of the IHA.	10.a.	1/27/2012
Submit policies and procedures for administering the Health Risk Stratification and Assessment to SPD beneficiaries, including use of the Member Evaluation Tool (MET) and other health information used for risk stratification.	10.b.	1/27/2012
Submit policies and procedures for monitoring and evaluation of the Cultural and Linguistic Services Program.	9.n.	1/27/2012
Submit policies and procedures for the provision of 24-hour interpreter services at all provider sites.	9.o.	1/27/2012
Submit policies and procedures for providing medically necessary services through out-of-network providers, including allowing access for the completion of covered services by an out-of-network or terminated provider.	9.q.	1/27/2012

WORK PLAN Attachement A

Required Health Plan Submissions

Deliverable Description	Del #	Date Due from Plan
Submit policies and procedures to ensure access for up to 12 months for SPD beneficiaries who have an ongoing relationship with a provider.	9.r.	1/27/2012
Submit Contractor's risk stratification mechanism or algorithm designed for the purpose of identifying newly enrolled SPD beneficiaries as high or low risk.	10.c.	2/3/2012
Submit the plan's risk assessment tool to be used to comprehensively assess an SPD beneficiaries' current health risk and help develop individualized care management plans.	10.d.	2/3/2012
Submit policies and procedures, including standards, for the provision of the following services for Members under Twenty-One (21) years of age: 1) Children's preventive services; 2) Immunizations; 3) Blood Lead screens; 4) Screening for Chlamydia; 5) EPSDT supplemental services.	10.e.	2/3/2012
Submit policies and procedures for the provision of adult preventive services, including immunization.	10.f.	2/3/2012
Submit policies and procedures for the provision of services to pregnant women, including: 1) Prenatal care; 2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines; 3) Comprehensive risk assessment tool for all pregnant women; 4) Referral to specialists.	10.g.	2/10/2012
Submit policies and procedures for the application and use of the Health Information Form (HIF) data submitted through the Member Evaluation Tool (MET).	10.k.	2/10/2012
Submit policies and procedures for the provision of: 1) Hospice care 2) Vision care – Lenses 3) Mental health services 4) Tuberculosis services	10.l.	2/10/2012
Submit a complete drug formulary.	10.n.	2/10/2012
Submit procedures for monitoring the coordination of care provided to Members. Include procedures used to monitor the provision of Basic Case Management.	11.a.	2/17/2012
Submit procedures for administering and monitoring the provision of Complex Case Management to Members. Include procedures to identify members who may benefit from complex case management services.	11.b.	2/17/2012
Submit policies and procedures for ensuring the provision of Person-Centered Planning for SPD beneficiaries as part of case management and coordination of care.	11.c.	2/17/2012
Submit policies and procedures for ensuring the provision of Discharge Planning.	11.d.	2/17/2012
Submit policies and procedures for the referral of Members under the age of 21 years that require complex case management services.	11.f.	2/24/2012
Submit policies and procedures for administration of a disease management program, including procedures for identification and referral of Members eligible to participate in the disease management program.	11.g.	2/24/2012
Submit policies and procedures for referral and coordination of care for Members in need of Specialty Mental Health Services from the local Medi-Cal mental health plan or other community resources.	11.h.	2/24/2012
Submit policies and procedures for resolving disputes between Contractor and the local mental health plan.	11.i.	2/24/2012

WORK PLAN Attachement A

Required Health Plan Submissions

Deliverable Description	Del #	Date Due from Plan
Submit policies and procedures for identification, referral and coordination of care for Members requiring alcohol or substance abuse treatment services from both within and, if necessary, outside the Contractor's Service Area.	11.j.	3/3/2012
Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).	11.k.	3/3/2012
Submit policies and procedures for case management coordination of care of Members who receive services through local school districts or school sites.	11.p.	3/5/2012
Submit policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program.	11.l.	3/9/2012
Submit policies and procedures for the identification, referral and coordination of care for Members with developmental disabilities in need of non-medical services from the local Regional Center and the DDS-administered Home and Community Based Waiver program. Include the duties of the Regional Center Liaison.	11.m.	3/9/2012
Submit policies and procedures for the identification, referral and coordination of care for Members at risk of developmental delay and eligible to receive services from the local Early Start program.	11.n.	3/9/2012
Submit policies and procedures for case management coordination of care of LEA services, including primary care physician involvement in the development of the Member's Individual Education Plan or Individual Family Service Plan.	11.o.	3/9/2012
Submit policies and procedures for assessment of transitional needs of members into and out of Complex Case Management services: 1) At the request of PCP or Member 2) Achievement of targeted outcomes 3) Change of healthcare setting 4) Loss or change in benefits 5) Member non-compliance	11.y.	3/16/2012
Submit executed Subcontracts, Memoranda of Understanding, or documentation substantiating Contractor's efforts to negotiate an agreement with the following programs or agencies: 1) California Children Services (CCS) 2) Maternal and Child Health 3) Child Health and Disability Prevention Program (CHDP) 4) Tuberculosis Direct Observed Therapy 5) Women, Infants, and Children Supplemental Nutrition Program (WIC) 6) Regional Centers for Services for Persons with Developmental Disabilities. 7) Local Governmental Agencies for Targeted Case Management services.	12.b.	3/16/2012
Submit policies and procedures for providing communication access to SPD beneficiaries in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English-proficient, or non-English speaking.	13.b.	3/16/2012
Submit policies and procedures for the training of Member Services staff.	13.e.	3/16/2012
Submit final draft of Member Identification Card and Member Services Guide (Evidence of Coverage and Disclosure Form).	13.g.	3/16/2012
Submit policies and procedures for Member selection of a primary care physician or non-physician medical practitioner. Include the mechanism used for allowing SPD beneficiaries to request a specialist to serve as their PCP.	13.i.	3/23/2012
Submit policies and procedures for Member assignment to a primary care physician. Include the use of FFS utilization data and other data in linking a SPD beneficiary to a PCP.	13.j.	3/23/2012

WORK PLAN Attachement A

Required Health Plan Submissions

Deliverable Description	Del #	Date Due from Plan
Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for Prior Authorization.	13.m.	3/23/2012
Submit policies and procedures relating to Contractor's Member Grievance System.	14.a.	3/23/2012
Submit policies and procedures for Contractor's oversight of the Member Grievance System for the receipts, processing and distribution including the expedited review of grievances. Please include a flow chart to demonstrate the process.	14.b.	3/23/2012
Submit policies and procedures relating to Contractor's Member Appeals process. Include Contractor's responsibilities in expedited Appeals and State Fair Hearings.	14.d.	3/23/2012
Submit documentation of employees (current and former State employees) who may present a conflict of interest.	1.a.	3/30/2012
If the Contractor is a subsidiary organization, submit an attestation by the parent organization that this Contract will be a high priority to the parent organization.	1.c.	3/30/2012
Submit policies and procedures for training and certification of marketing representatives.	15.a.	3/30/2012
Submit a description of training program, including the marketing representative's training/certification manual.	15.b.	3/30/2012
Submit an attestation that the medical decisions made by the medical director will not be unduly influenced by fiscal or administrative management.	1.d.	4/6/2012
Submit policies and procedures describing the representation and participation of Medi-Cal Members on Contractor's Public Policy Advisory Committee.	1.e.	4/6/2012
Submit Exhibit M-2: Statements as to each person identified in Section L. Technical Proposal Requirements, provision 1. Organization and Administration, a. 2) (Exhibit L) and 3). (Exhibit M-1) Title 28, CCR, Section 1300.51(d)(M)(2)	1.g.	4/6/2012
Submit Exhibits N-1 and N-2: Contracts for Administrative Services. Title 28, CCR, Section 1300.51(d)(N)(2)	1.h.	4/6/2012
If, within the last five (5) years, Contractor has had a contract terminated or not renewed for poor performance, nonperformance, or any other reason, Contractor shall submit a summary of the circumstances surrounding the termination or non-renewal. Describe the parties involved, including address(es) and telephone number(s). Describe the Contractor's corrective actions to prevent future occurrences of any problems identified.	1.i.	4/13/2012
Contractor shall describe provisions and arrangements, existing, and proposed, for including Medi-Cal Members in their Public Policy Advisory Committee development process. Identify the composition and meeting frequency of any committee participating in establishing the Contractor's public policy. Describe the frequency of the committee's report submission to the Contractor's Governing Body, and the Governing body, and the Governing Body's process for handling reports and recommendations after receipt.	1.j.	4/13/2012
Submit a completed MCO Baseline Assessment Form (see Appendix 5 of RFP). (For new contractors only)	3.a.	4/13/2012
If procuring a new MIS or modifying a current system, Contractor shall provide a detailed implementation plan that includes: 1) Outline of the tasks required; 2) The major milestones; 3) The responsible party for all related tasks. The implementation plan must also include: 1) A full description of the acquisition of software and hardware, including the schedule for implementation; 2) Full documentation of support for software and hardware by the manufacturer or other contracted party; 3) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results; 4) Documentation of system changes related to pending Health Insurance Portability and Accountability Act of 1996 requirements. (For new contractors only)	3.b.	4/13/2012

WORK PLAN Attachement A

Required Health Plan Submissions

Deliverable Description	Del #	Date Due from Plan
Submit a detailed description of how Proposer will monitor the flow of encounter data from provider level to the organization? (For new contractors only)	3.c.	4/13/2012
Submit Encounter data test tape produced from State supplied data. (For new contractors only)	3.d.	4/20/2012
Submit an attestation that Contractor's MIS is in compliance with the Health Insurance Portability and Accountability Act of 1996.	3.f.	4/20/2012
Submit the data security, backup, or other data disaster processes used in the event of a MIS failure. (For new contractors only)	3.g.	4/20/2012
Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems; 1) Financial 2) Member/Eligibility 3) Provider 4) Encounter/Claims 5) Quality Management/Utilization (For new contractors only)	3.h.	4/20/2012
Submit a sample and description of the following reports generated by the MIS; 1) Member roster 2) Provider Listing 3) Capitation payments 4) Cost and Utilization 5) System edits/audits 6) Claims payment status/processing 7) Quality Assurance 8) Utilization 9) Monitoring of Complaints (For new contractors only)	3.i.	4/20/2012
Submit a flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity.	4.a.	4/27/2012
Submit policies that specify the responsibility of the Governing Body in the QIS.	4.b.	4/27/2012
Submit policies for the QI Committee including membership, activities, roles and responsibilities.	4.c.	4/27/2012
Submit procedures outlining how providers will be kept informed of the written QIS, its activities and outcomes.	4.d.	4/27/2012
Submit policies and procedures related to the delegation of the QIS activities.	4.e.	5/4/2012
Submit boilerplate subcontract language showing accountability of delegated QIS functions and responsibilities.	4.f.	5/4/2012
Submit a written description of the QIS.	4.g.	5/4/2012
Policies and procedures to address how the Contractor will meet the requirements of: 1) External Accountability Set (EAS) Performance Measures 2) Quality Improvement Projects 3) Consumer Satisfaction Survey	4.h.	5/4/2012
Submit the aggregate results of pre-operational, existing or in expanded areas site review to DHCS at least six (6) weeks prior to Plan operation. The aggregate results shall include all data elements defined by DHCS. (For New Contractors Only)	4.k.	5/4/2012
Submit policies and procedures for reporting any disease or condition to public health authorities.	4.l.	5/11/2012
Submit policies and procedures for appropriate handling and maintenance of medical records regardless of form (electronic, paper, etc.).	4.n.	5/11/2012
Submit policies and procedures describing how Contractor will monitor provider to patient ratios to ensure they are within specified standards.	6.b.	5/11/2012

WORK PLAN Attachement A

Required Health Plan Submissions

Deliverable Description	Del #	Date Due from Plan
Submit policies and procedures regarding physician supervision of non-physician medical practitioners.	6.c.	5/11/2012
Submit policies and procedures for how Contractor will meet Federal requirements for access and reimbursement for in-Plan and/or out-of-Plan FQHC services.	6.f.	5/11/2012
Submit a policy regarding the availability of a health plan physician 24-hours a day, 7-days a week, and procedures for communicating with emergency room personnel.	6.h.	5/18/2012
Submit a report containing the names of all subcontracting provider groups (see Exhibit A, Attachment 6, provision 11 for format).	6.j.	5/18/2012
Submit an analysis demonstrating the ability of the Contractor's provider network to meet the ethnic, cultural, and linguistic needs of the Contractor's Members.	6.k.	5/18/2012
Submit policies and procedures that establish Traditional and Safety-Net Provider participation standards.	6.m.	5/18/2012
Submit an attestation as to the percentage of Traditional and Safety-Net Providers in the Contractor's network and agreement to maintain that percentage.	6.n.	5/18/2012
Submit policies and procedures for provider grievances.	7.a.	5/25/2012
Submit a written description of how Contractor will communicate the provider grievance process to subcontracting and non-contracting providers.	7.b.	5/25/2012
Submit a schedule of provider training to be conducted during year one of operation. Include date, time and location, and complete curriculum.	7.e.	5/25/2012
Submit protocols for communicating and interacting with all emergency departments in the Service Area.	7.g.	5/25/2012
Submit a list of appropriate hospitals available within the provider network that provide necessary high-risk pregnancy services.	10.h.	6/1/2012
Submit complete provider network showing the ability to serve sixty percent (60%) of the Eligible Beneficiaries, including SPD beneficiaries, in the county pursuant to the Contract.	6.a.	6/1/2012
Submit a complete list of specialists by type within the Contractor's network.	6.e.	6/1/2012
Submit a GeoAccess report (or similar) showing that the proposed provider network meets the appropriate time and distance standards set forth in the Contract.	6.g.	6/1/2012
Submit policies and procedures regarding timing of capitation payments to primary care providers or clinics.	8.a.	6/1/2012
Submit description of any physician incentive plans.	8.b.	6/1/2012
Submit policies regarding the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract, to any Medi-Cal member.	8.d.	6/1/2012
Submit Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Service Facilities subcontracts.	8.e.	6/1/2012
Submit policies and procedures for the reimbursement of Non-Contracting Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP).	8.f.	6/1/2012
Submit policies and procedures for the reimbursement to local health department and non-contracting family planning providers for the provision of family planning service, STD episode, and HIV testing and counseling.	8.g.	6/8/2012
Submit policies and procedures for the reimbursement of immunization services to local health department.	8.h.	6/8/2012
Submit policies and procedures for the timely referral and coordination of Covered Service to which the Contractor or subcontractor has objections to perform or otherwise support.	9.c.	6/8/2012
Submit policies and procedures for standing referrals.	9.d.	6/8/2012
Submit policies and procedures regarding access to Nurse Midwives and Nurse Practitioners.	9.f.	6/8/2012

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Required Health Plan Submissions

Deliverable Description	Del #	Date Due from Plan
Submit health education policies and procedures which include: 1) Administration and Oversight of the Health Education System; 2) Delivery of Health Education Programs, Services and Resources; and 3) Evaluation and Monitoring of the Health Education System.	10.i.	6/15/2012
Provide a list and schedule of all health education classes and/or programs that are offered by the plan, either directly or by subcontract.	10.j.	6/15/2012
Submit applicable section of Member Services Guide stating Member's right to access family planning services without prior authorization.	9.g.	6/15/2012
Submit policies and procedures for the provision of and access to: 1) Family planning services 2) Sexually transmitted disease treatment 3) HIV testing and counseling services 4) Pregnancy termination 5) Minor consent services 6) Immunizations	9.h.	6/15/2012
Submit a written description of the Cultural and Linguistic Services Program.	9.k.	6/15/2012
Submit standards and guidelines for the provision of Pharmaceutical services and prescribed Drugs.	10.m.	6/22/2012
Submit a process for review of drug formulary.	10.o.	6/22/2012
Submit policies and procedures for conducting drug utilization reviews.	10.p.	6/22/2012
Submit a timeline and work plan for the development and performance of a Group Needs Assessment. NEW COUNTIES ONLY	9.l.	6/22/2012
Submit policies and procedures for providing cultural competency, sensitivity or diversity training for staff, providers, and subcontractors.	9.m.	6/22/2012
Submit policies and procedures describing the membership of the Community Advisory Committee (CAC) and how the Contractor will ensure the CAC will be involved in appropriate policy decisions.	9.p.	6/22/2012
Submit policies and procedures for coordinating care of Members who are receiving services from a Targeted Case Management provider.	11.e.	6/29/2012
Submit a description of the cooperative arrangement Contractor has with the local school districts, including the subcontracts or written protocols/guidelines, if applicable.	11.q.	6/29/2012
Submit policies and procedures describing the cooperative arrangement that Contractor has regarding care for children in Foster Care.	11.r.	6/29/2012
Submit policies and procedures for identification and referral of Members eligible to participate in the HIV/AIDS Home and Community Based Waiver Program.	11.s.	6/29/2012
Submit policies and procedures for the provision of dental screening and covered medical services related to dental services.	11.t.	6/29/2012
Copy of Knox-Keene License	0	7/6/2012

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Required Health Plan Submissions

Deliverable Description	Del #	Date Due from Plan
Submit the following Knox-Keene license exhibits and forms reflecting current operation status: 1. Type of Organization 2. Individual Information Sheet 3. Contracts with Affiliated person, Principal Creditors and Providers of Administrative Services. 4. Other Controlling Persons. 5. In addition to Exhibits F, Contractor shall demonstrate compliance with requirements of Title 22, CCR, Sections 53874 and 53600. Identify any individual named in this item b. that was an employee of the State of California in the past 12 months. Describe their job position and function while a State employee.	1.f.	7/6/2012
Submit policies and procedures for coordination of care and case management of Members with the LHD TB Control Officer.	11.u.	7/6/2012
Submit policies and procedures for the assessment and referral of Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.	11.v.	7/6/2012
Submit the following Knox-Keene license exhibits reflecting projected financial viability: 1) Exhibit HH-1 2) Exhibit HH-2 (Title 28, CCR, Section 1300.76) 3) In addition to Exhibit HH-2, include projected Medi-Cal enrollment for each month and cumulative Member months for quarterly financial projections. (For new contractors only)	2.c.	7/6/2012
Submit Knox-Keene license Exhibit HH-6. Include the following: 1) Exhibit HH-6-a: 2) Exhibit HH-6-b: 3) Exhibit HH-6-c 4) Exhibit HH-6-d: 5) Exhibit HH-6-e: Title 28, CCR, Section 1300.51(d)(HH). (For new contractors only)	2.d.	7/6/2012
Fiscal Arrangements: Submit the following Knox-Keene license exhibits reflecting current operation status: 1) Exhibit II-1 2) Exhibit II-2 3) Exhibit II-3 Title 28, CCR, Section 1300.51(d)(II). (For new contractors only)	2.f.	7/6/2012
Procedures to identify and refer eligible Members for WIC services.	11.w.	7/13/2012
Submit policies and procedures for the assessment and subsequent disenrollment of Members eligible for the following services: 1) Long-term care 2) Major organ transplants 3) Waiver programs	11.x	7/13/2012
Submit executed subcontracts or documentation substantiating Contractor's efforts to enter into subcontracts with the LHD for the following public health services: 1) Family planning services; 2) STD services; 3) HIV testing and counseling; 4) Immunizations.	12.a.	7/13/2012

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Required Health Plan Submissions

Deliverable Description	Del #	Date Due from Plan
Executed MOU or documentation substantiating Contractor's efforts to negotiate a MOU with the local mental health plan.	12.c.	7/13/2012
Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and providers.	13.a.	7/20/2012
Submit the following consistent with the requirements of Exhibit E, Attachment 2, Provision 21. Confidentiality of Information. Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information.	13.c.	7/20/2012
Submit policies and procedures for addressing advance directives.	13.d.	7/20/2012
Submit policies and procedures regarding the development, content and distribution of Member information. Address appropriate reading level and translation of materials.	13.f.	7/20/2012
Submit policies and procedures for notifying Members of changes in availability or location of Covered Services.	13.h.	7/27/2012
Submit policies and procedures for notifying primary care provider that a member has selected or been assigned to the provider within 10-days.	13.k.	7/27/2012
Submit policies and procedures demonstrating how, upon entry into the Contractor's network, the relationship between traditional and safety-net providers and their patients is not disrupted, to the maximum extent possible. (For new contractors only)	13.l.	7/27/2012
Submit format for Quarterly Grievance Report.	14.c.	7/27/2012
Submit Contractor's marketing plan.	15.c.	8/3/2012
Submit copy of boilerplate request form used to obtain DHCS approval of participation in a marketing event.	15.d.	8/3/2012
Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting providers.	16.a.	8/3/2012
Submit policies and procedures for how Contractor will access and utilize enrollment data from DHCS.	16.b.	8/3/2012
Submit policies and procedures relating to Member disenrollment.	16.c.	8/3/2012
Submit the following consistent with the requirements of Exhibit G. Submit policies and procedures for compliance with the Health Insurance Portability and Accountability Act of 1996.	17.a.	8/3/2012